

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6190 CERTIFICATE OF DEATH

06185

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ambrose</u> Middle <u>Calvin</u> Last <u>Collins</u>			4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3 1879</u>		9. AGE (In years last birthday) <u>79 7/2 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Collins</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Virgil Collins, Snow Hill, Md. RFD #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertensive</u> DUE TO (c) <u>cardio renal disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> 19 to <u>5/5/59</u> 19, that I last saw the deceased alive on <u>5/4/59</u> 19, and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Green</u> M.D.				ADDRESS (Street, city or town, state) <u>Snow Hill Md</u>		DATE SIGNED <u>5/6/59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Reming</u>				ADDRESS <u>Snow Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

CERTIFICATE OF DEATH

WILLIAM BOND

Name of Deceased		WILLIAM BOND	
Date of Death		JAN 10 1914	
Place of Death		BALTIMORE, MARYLAND	
Age		65	
Sex		Male	
Race		White	
Marital Status		Married	
Cause of Death		Heart Disease	
Occupation		Carpenter	
Residence		1234 Main St, Baltimore, Md	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		JAN 15 1914	
Place of Registration		BALTIMORE, MARYLAND	



FOR STATE  
HEALTH DEPT.

6189

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester Co., MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>years</u> x	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Flower St</u>	
3. NAME OF DECEASED (Type or print) <u>Wm Thomas Collins</u> First Middle Last		4. DATE OF DEATH <u>May 30 1959</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 - 1915</u> last birthday yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmill</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edward Collins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emma Shadlock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-6599</u>	
17. INFORMANT <u>Elmora Kaydon (Sister)</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - (Suicide)</u> 982x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Cut throat</u> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drinking Alcohols + an argument</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Throat cut with a knife</u>	
20c. TIME OF INJURY Month, Day, Year <u>May 30 1959</u> Hour <u>6:45</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ed Collins home</u>		20f. (City or town) <u>Berlin</u> (County) <u>Worcester</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. F. Sartorius Sr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. F. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Broton Cem.</u>		22d. LOCATION (City, town, or county) <u>Massengo, Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - Newchurch, Va.</u>		24a. REC'D BY REGISTRAR <u>June 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

NOT STATE  
DEATH OF

1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 1880

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RESIDENCE: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

1880

## 6191 CERTIFICATE OF DEATH

06187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selbyville Del. R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Rachel</b> <sup>First</sup> <b>Ann</b> <sup>Middle</sup> <b>Harper</b> <sup>Last</sup>				4. DATE OF DEATH <b>May</b> <sup>Month</sup> <b>28</b> <sup>Day</sup> <b>59</b> <sup>Year</sup>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1892</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chef-cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alfred Walters</b>				14. MOTHER'S MAIDEN NAME <b>Alice Mae Showell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-09-6726</b>		17. INFORMANT <b>Marie Wilkens 224 N. 60th St. Phila. Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443x</b> <b>443x</b> DUE TO <b>443x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>degenerative heart disease</b> (c) <b>Essential Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>18 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-3</b> , 19 <b>59</b> , to <b>5/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5/27</b> , 19 <b>59</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr. M.D.</b>				ADDRESS (Street, city or town, state) <b>Berlin, Md</b>		DATE SIGNED <b>5/29/59</b>	
PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr. MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rolling Green Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry A. Watson</b>				ADDRESS <b>Pocomoke City, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH Jan 5, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Attorney	
7. MARITAL STATUS Single		8. RACE White	
9. RELIGION Methodist		10. EDUCATION High School	
11. PRESENT ADDRESS 2435 16th St NW Washington, D.C.		12. DATE OF DEATH Apr 4, 1968	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide	
15. PLACE OF DEATH Memphis, Tennessee		16. COUNTY Shelby	
17. CITY Memphis		18. STATE Tennessee	
19. ZIP CODE 38103		20. COUNTY OF DEATH Shelby	
21. CITY OF DEATH Memphis		22. STATE OF DEATH Tennessee	
23. ZIP CODE OF DEATH 38103		24. COUNTY OF DEATH Shelby	
25. CITY OF DEATH Memphis		26. STATE OF DEATH Tennessee	
27. ZIP CODE OF DEATH 38103		28. COUNTY OF DEATH Shelby	
29. CITY OF DEATH Memphis		30. STATE OF DEATH Tennessee	
31. ZIP CODE OF DEATH 38103		32. COUNTY OF DEATH Shelby	
33. CITY OF DEATH Memphis		34. STATE OF DEATH Tennessee	
35. ZIP CODE OF DEATH 38103		36. COUNTY OF DEATH Shelby	
37. CITY OF DEATH Memphis		38. STATE OF DEATH Tennessee	
39. ZIP CODE OF DEATH 38103		40. COUNTY OF DEATH Shelby	
41. CITY OF DEATH Memphis		42. STATE OF DEATH Tennessee	
43. ZIP CODE OF DEATH 38103		44. COUNTY OF DEATH Shelby	
45. CITY OF DEATH Memphis		46. STATE OF DEATH Tennessee	
47. ZIP CODE OF DEATH 38103		48. COUNTY OF DEATH Shelby	
49. CITY OF DEATH Memphis		50. STATE OF DEATH Tennessee	
51. ZIP CODE OF DEATH 38103		52. COUNTY OF DEATH Shelby	
53. CITY OF DEATH Memphis		54. STATE OF DEATH Tennessee	
55. ZIP CODE OF DEATH 38103		56. COUNTY OF DEATH Shelby	
57. CITY OF DEATH Memphis		58. STATE OF DEATH Tennessee	
59. ZIP CODE OF DEATH 38103		60. COUNTY OF DEATH Shelby	
61. CITY OF DEATH Memphis		62. STATE OF DEATH Tennessee	
63. ZIP CODE OF DEATH 38103		64. COUNTY OF DEATH Shelby	
65. CITY OF DEATH Memphis		66. STATE OF DEATH Tennessee	
67. ZIP CODE OF DEATH 38103		68. COUNTY OF DEATH Shelby	
69. CITY OF DEATH Memphis		70. STATE OF DEATH Tennessee	
71. ZIP CODE OF DEATH 38103		72. COUNTY OF DEATH Shelby	
73. CITY OF DEATH Memphis		74. STATE OF DEATH Tennessee	
75. ZIP CODE OF DEATH 38103		76. COUNTY OF DEATH Shelby	
77. CITY OF DEATH Memphis		78. STATE OF DEATH Tennessee	
79. ZIP CODE OF DEATH 38103		80. COUNTY OF DEATH Shelby	
81. CITY OF DEATH Memphis		82. STATE OF DEATH Tennessee	
83. ZIP CODE OF DEATH 38103		84. COUNTY OF DEATH Shelby	
85. CITY OF DEATH Memphis		86. STATE OF DEATH Tennessee	
87. ZIP CODE OF DEATH 38103		88. COUNTY OF DEATH Shelby	
89. CITY OF DEATH Memphis		90. STATE OF DEATH Tennessee	
91. ZIP CODE OF DEATH 38103		92. COUNTY OF DEATH Shelby	
93. CITY OF DEATH Memphis		94. STATE OF DEATH Tennessee	
95. ZIP CODE OF DEATH 38103		96. COUNTY OF DEATH Shelby	
97. CITY OF DEATH Memphis		98. STATE OF DEATH Tennessee	
99. ZIP CODE OF DEATH 38103		100. COUNTY OF DEATH Shelby	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6192 CERTIFICATE OF DEATH

06188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>67 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>	
		f. STREET ADDRESS <b>PITTS STREET</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>LEE</b> Last <b>HOLLOWAY</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 25, 1890</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>POWELLVILLE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MORTIN Holloway Sr.</b>		14. MOTHER'S MAIDEN NAME <b>JULIA Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. ARTHUR Holloway</b>		Address <b>BERLIN, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Hypertension + Enlarged Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 25, 1959</b> , to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 6, 1959</b> , and that death occurred at <b>6:00 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. R. Law</b> M.D.		ADDRESS (Street, city or town, state) <b>Berlin Md</b> DATE SIGNED <b>5-8-1959</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 9, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barclay Funeral Home, Berlin, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

06189

6193

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1 BAKER ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE WISE JOHNSON</b>		4. DATE OF DEATH Month Day Year <b>MAY 7 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 21, 1882</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>M. WILLIS WISE</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIANA MARSHALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT Address <b>MRS. PAUL DAVIS BERLIN MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>illness</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-59</b> 19 to <b>5-7-59</b> 19, that I lost the deceased alive on <b>5-5-59</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford E. Schott</b> M.D.		ADDRESS (Street, city or town, state) <b>310 N. Main Berlin MD</b>	
DATE SIGNED <b>3-10-59</b>			
PHYSICIAN'S NAME (Type) <b>CLIFFORD E. SCHOTT MD</b>		<b>310 N. MAIN - BERLIN MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna R. Burbage</b> ADDRESS <b>Berlin MD</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6188 CERTIFICATE OF DEATH

06190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>22 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>805 Walnut Street</u>				d. STREET ADDRESS <u>805 Walnut Sreet</u>					
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>B.</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1885</u>			
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>David Jones</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Slocomb</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Blanche L. Jones, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, acute., fatal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Emphysema, chronic, very severe.</u> years. (c) <u>Myocarditis, mod. severe, chronic</u> years.								INTERVAL BETWEEN ONSET AND DEATH <u>few minutes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Abdominal Aortic Aneurism (2) Underweight &amp; undernutrition</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>May 6, 1959</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pocomoke City, Worcester, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 22, 1953</u> to <u>April 18, 1959</u> , that I last saw the deceased alive on <u>April 22, 1959</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>N.E. Sartorius, Jr.</u> M.D. <u>114 Market St., Pocomoke City, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parksley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parksley Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

# CERTIFICATE OF DEATH

101746

<p>1. Name of deceased                  [Illegible text]</p>		<p>2. Sex                  [Illegible text]</p>		<p>3. Age                  [Illegible text]</p>	
<p>4. Date of birth                  [Illegible text]</p>		<p>5. Place of birth                  [Illegible text]</p>		<p>6. Date of death                  [Illegible text]</p>	
<p>7. Cause of death                  [Illegible text]</p>		<p>8. Manner of death                  [Illegible text]</p>		<p>9. Signature of medical officer                  [Illegible text]</p>	
<p>10. Signature of registrar                  [Illegible text]</p>		<p>11. Date of registration                  [Illegible text]</p>		<p>12. Place of registration                  [Illegible text]</p>	

101746



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 6194 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>41 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LEE</b> Last <b>JUSTIS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John C. Thornes</b>	
14. MOTHER'S MAIDEN NAME <b>Lavania Taylor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. I. W. Justis, Pocomoke City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the</b> <b>152.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19 <b>May 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 15</b> , 19 <b>59</b> , and that death occurred at <b>8:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Cohen</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Shore Hill Md 5/16/59</b>	
PHYSICIAN'S NAME (Type) <b>Paul Cohen, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. H.</b>	

CERTIFICATE OF DEATH

NEW YORK  
COUNTY  
DEPARTMENT OF HEALTH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SURVIVOR		SIGNATURE OF OFFICIAL	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	





## 6195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06192

Item 4, Film G-243 6/1/59.cac

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Showell</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>RAY</u> Last <u>LEWIS</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 12 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store &amp; Motel operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>King Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Ocea E. Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>21632-7381</u>		17. INFORMANT <u>MRS H Ray Lewis Showell, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>F. J. Townsend, Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>MAY 26, 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbay</u>				ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Collier &amp; Kneiss</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18 192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF BIRTH</p>		<p>7. DATE OF DEATH</p>		<p>8. TIME OF DEATH</p>	
<p>9. OCCUPATION</p>		<p>10. CAUSE OF DEATH</p>		<p>11. MANNER OF DEATH</p>		<p>12. SIGNATURE OF EXAMINER</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF JURY</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF CLERK</p>	
<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF NURSE</p>		<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF FUNERAL HOME</p>	
<p>21. SIGNATURE OF BURIAL SOCIETY</p>		<p>22. SIGNATURE OF CEMETERY</p>		<p>23. SIGNATURE OF INTERMENT</p>		<p>24. SIGNATURE OF RECORDS</p>	
<p>25. SIGNATURE OF VITALS</p>		<p>26. SIGNATURE OF DEATH</p>		<p>27. SIGNATURE OF BIRTH</p>		<p>28. SIGNATURE OF MARRIAGE</p>	
<p>29. SIGNATURE OF DIVORCE</p>		<p>30. SIGNATURE OF ADULTERY</p>		<p>31. SIGNATURE OF FORNICATION</p>		<p>32. SIGNATURE OF SODOMY</p>	
<p>33. SIGNATURE OF LARCENY</p>		<p>34. SIGNATURE OF BURGLARY</p>		<p>35. SIGNATURE OF ROBBERY</p>		<p>36. SIGNATURE OF KIDNAPING</p>	
<p>37. SIGNATURE OF OBSCENE EXPOSURE</p>		<p>38. SIGNATURE OF OBSCENE LANGUAGE</p>		<p>39. SIGNATURE OF OBSCENE ACTS</p>		<p>40. SIGNATURE OF OBSCENE WRITINGS</p>	
<p>41. SIGNATURE OF OBSCENE PICTURES</p>		<p>42. SIGNATURE OF OBSCENE FILMS</p>		<p>43. SIGNATURE OF OBSCENE RECORDS</p>		<p>44. SIGNATURE OF OBSCENE ARTS</p>	
<p>45. SIGNATURE OF OBSCENE LITERATURE</p>		<p>46. SIGNATURE OF OBSCENE MUSIC</p>		<p>47. SIGNATURE OF OBSCENE DANCE</p>		<p>48. SIGNATURE OF OBSCENE THEATRE</p>	
<p>49. SIGNATURE OF OBSCENE CIRCUS</p>		<p>50. SIGNATURE OF OBSCENE CARNIVAL</p>		<p>51. SIGNATURE OF OBSCENE FAIR</p>		<p>52. SIGNATURE OF OBSCENE EXHIBITION</p>	
<p>53. SIGNATURE OF OBSCENE CONCERT</p>		<p>54. SIGNATURE OF OBSCENE MEETING</p>		<p>55. SIGNATURE OF OBSCENE RALLY</p>		<p>56. SIGNATURE OF OBSCENE DEMONSTRATION</p>	
<p>57. SIGNATURE OF OBSCENE PLEA</p>		<p>58. SIGNATURE OF OBSCENE TRIAL</p>		<p>59. SIGNATURE OF OBSCENE VERDICT</p>		<p>60. SIGNATURE OF OBSCENE SENTENCE</p>	
<p>61. SIGNATURE OF OBSCENE APPEAL</p>		<p>62. SIGNATURE OF OBSCENE REVERSAL</p>		<p>63. SIGNATURE OF OBSCENE PARDON</p>		<p>64. SIGNATURE OF OBSCENE COMMUTATION</p>	
<p>65. SIGNATURE OF OBSCENE EXECUTION</p>		<p>66. SIGNATURE OF OBSCENE BURIAL</p>		<p>67. SIGNATURE OF OBSCENE INTERMENT</p>		<p>68. SIGNATURE OF OBSCENE CREMATION</p>	
<p>69. SIGNATURE OF OBSCENE ANATOMY</p>		<p>70. SIGNATURE OF OBSCENE PHYSIOLOGY</p>		<p>71. SIGNATURE OF OBSCENE MEDICINE</p>		<p>72. SIGNATURE OF OBSCENE SURGERY</p>	
<p>73. SIGNATURE OF OBSCENE DENTISTRY</p>		<p>74. SIGNATURE OF OBSCENE OPTIC</p>		<p>75. SIGNATURE OF OBSCENE AURAL</p>		<p>76. SIGNATURE OF OBSCENE NASAL</p>	
<p>77. SIGNATURE OF OBSCENE THROAT</p>		<p>78. SIGNATURE OF OBSCENE LUNGS</p>		<p>79. SIGNATURE OF OBSCENE LIVER</p>		<p>80. SIGNATURE OF OBSCENE STOMACH</p>	
<p>81. SIGNATURE OF OBSCENE SMALL</p>		<p>82. SIGNATURE OF OBSCENE LARGE</p>		<p>83. SIGNATURE OF OBSCENE BLADDER</p>		<p>84. SIGNATURE OF OBSCENE UTERUS</p>	
<p>85. SIGNATURE OF OBSCENE VAGINA</p>		<p>86. SIGNATURE OF OBSCENE PENIS</p>		<p>87. SIGNATURE OF OBSCENE TESTIS</p>		<p>88. SIGNATURE OF OBSCENE PROSTATE</p>	
<p>89. SIGNATURE OF OBSCENE SPERM</p>		<p>90. SIGNATURE OF OBSCENE OVUM</p>		<p>91. SIGNATURE OF OBSCENE EMBRYO</p>		<p>92. SIGNATURE OF OBSCENE FETUS</p>	
<p>93. SIGNATURE OF OBSCENE PLACENTA</p>		<p>94. SIGNATURE OF OBSCENE CORD</p>		<p>95. SIGNATURE OF OBSCENE BLOOD</p>		<p>96. SIGNATURE OF OBSCENE URINE</p>	
<p>97. SIGNATURE OF OBSCENE SWEAT</p>		<p>98. SIGNATURE OF OBSCENE TEARS</p>		<p>99. SIGNATURE OF OBSCENE SALIVA</p>		<p>100. SIGNATURE OF OBSCENE SPIT</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6196 CERTIFICATE OF DEATH

06193

Reg./Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route #1</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Snow Hill Route #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Sampson</u> Middle <u>J.</u> Last <u>Shackley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1895</u>
9. AGE (In years last birthday) <u>63 7/8</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Safety</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTH PLACE (State or foreign country) <u>Piney Grove, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kindall Shackley</u>		14. MOTHER'S MAIDEN NAME <u>Emma Brittingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>18-09-6900</u>	
17. INFORMANT <u>Mrs Riley Taylor</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchiectasis with Asthma</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>  <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism and Pneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-5-59</u> , 19 <u>59</u> , to <u>5-12-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-8-59</u> , 19 <u>59</u> , and that death occurred at <u>12:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u>		M.D. <u>104 Bay St</u> DATE SIGNED <u>5-12-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>		<u>Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 15/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>md Ave. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Route #1 md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Ginn</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

FILE NO.

DATE

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6197 CERTIFICATE OF DEATH

06194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 2</b>				d. STREET ADDRESS <b>Route # 2</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>H.</b> Last <b>Tingle</b>				4. DATE OF DEATH Month <b>5</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>AA.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-1870</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY Tingle</b>				14. MOTHER'S MAIDEN NAME <b>Purnell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Annie B. Tingle, Berlin, Md Rt #2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Several years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>10-22</b> , 19 <b>59</b> , to <b>5-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-16</b> , 19 <b>59</b> , and that death occurred at <b>2:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr. M.D.</b>				ADDRESS (Street, city or town, state) <b>Berlin, Md</b>			
PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr. M.D.</b>				DATE SIGNED <b>5/20/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.E. Stewart</b>				24a. REC'D BY REGISTRAR <b>FUNERAL HOME, SALISBURY, MD</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	





## 6198 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural-Pocomoke City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #3</b>				d. STREET ADDRESS <b>RFD #3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BURTON</b> Middle <b>J.</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 13, 1882</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Watson</b>				14. MOTHER'S MAIDEN NAME <b>Annie Melvin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-20-0547</b>		17. INFORMANT <b>Elmer B. Watson, Portsmouth, Virginia</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>199.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma, Abdominal</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 8, 1958</b> to <b>May 19, 1959</b> , that I last saw the deceased alive on <b>May 19, 1959</b> , and that death occurred at <b>930 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>302 Market St., Pocomoke, Md.</b> DATE SIGNED <b>5/19/59</b>							
ACTUAL SIGNATURE <b>Charles W. Trader, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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